

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041764</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Rosewood Care Center St Charles</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2000</u> to <u>06/30/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>850 Dunham Road</u> <u>St. Charles</u> <u>60174</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Kane</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(630) 443-4400</u> Fax # <u>(630) 443-4460</u>		Paid Preparer (Signed) <u>See Accountants' Compilation Report</u> (Date) _____ (Print Name and Title) <u>Cindy A. Tefteller</u> _____ (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> _____ <u>233 East Center Drive, Alton, IL 62002</u> _____ (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>																									
IDPA ID Number: <u>431683970001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>04/07/99</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
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	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____																											
In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>																											

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center St Charles# 0041764 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>5,802</u>	<u>5,802</u>	8
9	SNF/PED					9
10	ICF	<u>2,808</u>	<u>15,291</u>		<u>18,099</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,808</u>	<u>15,291</u>	<u>5,802</u>	<u>23,901</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 66.14%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/28/99

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/28/99 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 40 and days of care provided 5,802Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2001 Fiscal Year: 06/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Rosewood Care Center St Charles

0041764

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	188,169	13,318	4,860	206,347		206,347		206,347		1
2	Food Purchase		108,808		108,808		108,808	(2,697)	106,111		2
3	Housekeeping	126,831	21,180		148,011		148,011		148,011		3
4	Laundry	31,881	13,355		45,236		45,236		45,236		4
5	Heat and Other Utilities			102,961	102,961		102,961	184	103,145		5
6	Maintenance	24,280	8,860	77,015	110,155		110,155	16,805	126,960		6
7	Other (specify):* Sanitation Services			7,820	7,820		7,820		7,820		7
8	TOTAL General Services	371,161	165,521	192,656	729,338		729,338	14,292	743,630		8
	B. Health Care and Programs										
9	Medical Director			1,044	1,044		1,044		1,044		9
10	Nursing and Medical Records	1,259,667	102,336	107,567	1,469,570		1,469,570		1,469,570		10
10a	Therapy	28,246	2,276	311,839	342,361		342,361	14,879	357,240		10a
11	Activities	51,542	5,274	1,998	58,814		58,814		58,814		11
12	Social Services	42,460	48	2,600	45,108		45,108		45,108		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,381,915	109,934	425,048	1,916,897		1,916,897	14,879	1,931,776		16
	C. General Administration										
17	Administrative			119,926	119,926		119,926	(935)	118,991		17
18	Directors Fees										18
19	Professional Services			6,247	6,247		6,247	84,162	90,409		19
20	Dues, Fees, Subscriptions & Promotions			28,168	28,168		28,168	(8,264)	19,904		20
21	Clerical & General Office Expenses	151,246	18,002	29,319	198,567		198,567	98,211	296,778		21
22	Employee Benefits & Payroll Taxes			224,779	224,779		224,779	28,316	253,095		22
23	Inservice Training & Education										23
24	Travel and Seminar			812	812		812	564	1,376		24
25	Other Admin. Staff Transportation			5,991	5,991		5,991	27,047	33,038		25
26	Insurance-Prop.Liab.Malpractice			29,705	29,705		29,705	4,138	33,843		26
27	Other (specify):*										27
28	TOTAL General Administration	151,246	18,002	444,947	614,195		614,195	233,239	847,434		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,904,322	293,457	1,062,651	3,260,430		3,260,430	262,410	3,522,840		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Rosewood Care Center St Charles #0041764 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			207	207		207	220,772	220,979			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			164,856	164,856		164,856	365,924	530,780			32
33	Real Estate Taxes			83,459	83,459		83,459		83,459			33
34	Rent-Facility & Grounds			1,004,601	1,004,601		1,004,601	(993,126)	11,475			34
35	Rent-Equipment & Vehicles			1,773	1,773		1,773		1,773			35
36	Other (specify):*											36
37	TOTAL Ownership			1,254,896	1,254,896		1,254,896	(406,430)	848,466			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		129,918	10,535	140,453		140,453	(1,139)	139,314			39
40	Barber and Beauty Shops			17,336	17,336		17,336		17,336			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		129,918	82,074	211,992		211,992	(1,139)	210,853			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,904,322	423,375	2,399,621	4,727,318		4,727,318	(145,159)	4,582,159			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles

0041764

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,352)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,149)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(22,753)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,139)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(345)	2		13
14	Non-Care Related Interest	(164,856)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,310)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,611)	20		28
29	Other-Attach Schedule Marketing Salary	(70,388)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (278,903)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	133,744	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 133,744		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (145,159)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center St Charles

ID# 0041764

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salary	\$ (70,388)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(70,388)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center St Charles

0041764

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,697)	0	0	0	0	0	0	0	0	0	0	(2,697)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	184	0	0	0	0	0	0	0	0	184	5
6	Maintenance	0	0	16,805	0	0	0	0	0	0	0	0	16,805	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,697)	0	16,989	0	0	0	0	0	0	0	0	14,292	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	14,879	0	0	0	0	0	0	0	0	0	14,879	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	14,879	0	0	0	0	0	0	0	0	0	14,879	16
	C. General Administration													
17	Administrative	0	(119,926)	118,991	0	0	0	0	0	0	0	0	(935)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	52,290	31,872	0	0	0	0	0	0	0	0	84,162	19
20	Fees, Subscriptions & Promotions	(8,921)	0	657	0	0	0	0	0	0	0	0	(8,264)	20
21	Clerical & General Office Expenses	(78,537)	276	176,472	0	0	0	0	0	0	0	0	98,211	21
22	Employee Benefits & Payroll Taxes	0	0	28,316	0	0	0	0	0	0	0	0	28,316	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	564	0	0	0	0	0	0	0	0	564	24
25	Other Admin. Staff Transportation	0	0	27,047	0	0	0	0	0	0	0	0	27,047	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,138	0	0	0	0	0	0	0	0	4,138	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(87,458)	(67,360)	388,057	0	0	0	0	0	0	0	0	233,239	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(90,155)	(52,481)	405,046	0	0	0	0	0	0	0	0	262,410	29

Summary B

Facility Name & ID Number	Rosewood Care Center St Charles	#	0041764	Report Period Beginning:	07/01/2000	Ending:	06/30/2001
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Rosewood Care Center St Charles# 0041764

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Management Fee	\$ 119,926	HSM Management Services, Inc.	100.00%	\$	\$ (119,926)
2	V						
3	V	10a Therapy	311,839	Rosewood Therapy Services, Inc.	0.00%	326,718	14,879
4	V						
5	V	34 Rent	1,004,601	St. Charles Real Estate LLC	0.00%		(1,004,601)
6	V	30 Depreciation		St. Charles Real Estate LLC		198,433	198,433
7	V	32 Interest		St. Charles Real Estate LLC		541,550	541,550
8	V	19 Professional Fees		St. Charles Real Estate LLC		52,290	52,290
9	V	21 Office Expense		St. Charles Real Estate LLC		276	276
10	V	32 Amortization of Loan Fees		St. Charles Real Estate LLC		11,983	11,983
11	V						
12	V						
13	V						
14	Total		\$ 1,436,366			\$ 1,131,250	\$ * (305,116)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles# 0041764Report Period Beginning: 07/01/2000Ending: 06/30/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation - Start Up Costs	\$	HSM Management Servces Inc.	100.00%	\$ 900	\$ 900
16	V	17 Administrative Salaries - Start Up		HSM Management Servces Inc.	100.00%	5,880	5,880
17	V	22 Payroll Taxes - Start Up Costs		HSM Management Servces Inc.	100.00%	492	492
18	V	24 Transportation - Start Up Costs		HSM Management Servces Inc.	100.00%	564	564
19	V	25 Other Admin Travel - Start Up		HSM Management Servces Inc.	100.00%	3,504	3,504
20	V	17 Administrative - Start Up Costs		HSM Management Servces Inc.	100.00%	7,932	7,932
21	V	34 Rent - Start Up Costs		HSM Management Servces Inc.	100.00%	307	307
22	V						
23	V	17 See Schedule VIII		HSM Management Servces Inc.	100.00%	105,179	105,179
24	V	21 See Schedule VIII		HSM Management Servces Inc.	100.00%	177,129	176,472
25	V	22 See Schedule VIII		HSM Management Servces Inc.	100.00%	27,824	27,824
26	V	25 See Schedule VIII		HSM Management Servces Inc.	100.00%	23,543	23,543
27	V	30 See Schedule VIII		HSM Management Servces Inc.	100.00%	21,439	21,439
28	V	34 See Schedule VIII		HSM Management Servces Inc.	100.00%	11,168	11,168
29	V	19 See Schedule VIII		HSM Management Servces Inc.	100.00%	31,872	31,872
30	V	26 See Schedule VIII		HSM Management Servces Inc.	100.00%	4,138	4,138
31	V	6 See Schedule VIII		HSM Management Servces Inc.	100.00%	16,805	16,805
32	V	5 See Schedule VIII		HSM Management Servces Inc.	100.00%	184	184
33	V	20 See Schedule VIII		HSM Management Servces Inc.	100.00%	615	657
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 439,475	\$ * 438,860

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Rosewood Care Center St Charles # 0041764 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	741,851	3	5.59%	Salary	\$ 35,641	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	220,617	3	5.59%	Salary	11,880	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 47,521		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles # 0041764 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.
 Street Address 11701 Borman Drive, Suite 315
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Salaries - Officers	Total Cost	75,137,033	17	\$ 849,990	\$ 849,990	4,200,755	\$ 47,521	1
2	21 Salaries - Other	Total Cost	75,137,033	17	2,658,369	2,658,369	4,200,755	148,624	2
3	22 Payroll Taxes	Total Cost	75,137,033	17	282,151		4,200,755	15,774	3
4	22 Employee Benefits	Total Cost	75,137,033	17	140,469		4,200,755	7,853	4
5	25 Travel	Total Cost	75,137,033	17	180,072		4,200,755	10,067	5
6	30 Depreciation	Total Cost	75,137,033	17	351,550		4,200,755	19,654	6
7	34 Building Rent	Total Cost	75,137,033	17	199,753		4,200,755	11,168	7
8	19 Professional Services	Total Cost	75,137,033	17	570,072		4,200,755	31,872	8
9	21 Telephone	Total Cost	75,137,033	17	200,687		4,200,755	11,220	9
10	26 Insurance	Total Cost	75,137,033	17	74,012		4,200,755	4,138	10
11	21 Taxes & Licenses	Total Cost	75,137,033	17	11,527		4,200,755	644	11
12	21 Office Supplies	Total Cost	75,137,033	17	285,895		4,200,755	15,984	12
13	6 Maintenance	Total Cost	75,137,033	17	300,583		4,200,755	16,805	13
14	5 Heat & Other Utilities	Total Cost	75,137,033	17	3,293		4,200,755	184	14
15	20 Dues & Subscriptions	Total Cost	75,137,033	17	11,759		4,200,755	657	15
16	17 Direct - Admin	Direct Cost	1	1	57,658	57,658	1	57,658	16
17	17 Direct - Admin	Direct Cost	16	16	857,236	857,236	0	0	17
18	22 Direct - Payroll Taxes	Direct Cost	1	1	4,197		1	4,197	18
19	22 Direct - Payroll Taxes	Direct Cost	16	16	51,221		0	0	19
20	30 Direct - Depreciation	Direct Cost	1	1	1,785		1	1,785	20
21	30 Direct - Depreciation	Direct Cost	16	16	25,903		0	0	21
22	25 Direct - Travel	Direct Cost	1	1	13,476		1	13,476	22
23	25 Direct - Travel	Direct Cost	16	16	125,726		0	0	23
24									24
25	TOTALS				\$ 7,257,384	\$ 4,423,253		\$ 419,281	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	Firstar		X	Mortgage	Varies	6/98	\$ 6,306,490	\$ 5,822,682			\$ 557,032	1							
2	Less: Related Party Interest Income Offset										(15,482)	2							
3	Amortization of Loan Fees										11,983	3							
4	Less: Interest Income Offset										(22,753)	4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 6,306,490	\$ 5,822,682				\$ 530,780	9						
	B. Non-Facility Related*																		
10	Firstar		X	Mortgage	Varies	6/98	1,208,253	1,115,691			106,734	10							
11	Less Related Party Interest Income Offset										(2,966)	11							
12	Amortization of Loan Fees										2,296	12							
13												13							
14	TOTAL Non-Facility Related						\$ 1,208,253	\$ 1,115,691				\$ 106,064	14						
15	TOTALS (line 9+line14)						\$ 7,514,743	\$ 6,938,373				\$ 636,844	15						

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center St Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0041764

CONTACT PERSON REGARDING THIS REPORT Lou Netemeyer

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>09-26-226-008</u>	<u></u>	\$ <u>83,824.96</u>	\$ <u>83,824.96</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>83,824.96</u>	\$ <u>83,824.96</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,252
 B. General Construction Type:
 Exterior Brick Veneer
 Frame Steel
 Number of Stories 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	8.35 Acres	1994	\$ 1,714,398	1
2					2
3	TOTALS	#VALUE!		\$ 1,714,398	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99			1999	\$ 5,353,402	\$	40	\$ 133,835	\$ 133,835	\$ 267,670	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Site Development			1999	555,639		25	22,226	22,226	44,451	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21	Facility Leaseholds:										21
22	Computer Cabling			2001	2,895	207	7	207		207	22
23											23
24											24
25											25
26											26
27	Leasehold Improvements - Management Company										27
28	Office Construction/Improvements			1995	428		5			428	28
29	Office Design			1995	39		5			39	29
30	Office Shelving			1996	91		4			91	30
31	Office Expansion			1996	404		4			404	31
32	Office Expansion			1997	1,082		3			1,082	32
33	Office Expansion			1998	610		3	203	203	565	33
34	Office Addition			1999	301		3	100	100	201	34
35	Door Locks			1999	150		3	51	51	79	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,915,041	\$ 207		\$ 156,622	\$ 156,415	\$ 315,217	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 463,811	\$	\$ 51,696	\$ 51,696	5-7 Yrs	\$ 117,188	71
72	Current Year Purchases	44,231		4,028	4,028	5-7 Yrs	4,028	72
73	Fully Depreciated Assets	14,862					14,862	73
74								74
75	TOTALS	\$ 522,904	\$	\$ 55,724	\$ 55,724		\$ 136,078	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$ 33,797	\$	\$ 8,633	\$ 8,633	4 Yrs	\$ 20,246	76
77										77
78										78
79										79
80	TOTALS			\$ 33,797	\$	\$ 8,633	\$ 8,633		\$ 20,246	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,186,140	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 207	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 220,979	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 220,772	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 471,541	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO SCHEDULE NOT APPLICABLE - ONLY HIRE CERTIFIED AIDES If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	23,217	\$ 156,125	\$	23,217	\$ 156,125	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		4,401	30,002		4,401	30,002	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		24,722	140,591	2,276	24,722	142,867	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				117,425		117,425	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory, X-Ray, Enterals Other (specify): & Specialty Beds	39-8				9,396	12,493		21,889	13
14	TOTAL			\$	52,340	\$ 336,114	\$ 132,194	52,340	\$ 468,308	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 457,243	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,000)	708,584		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,617		6
7	Other Prepaid Expenses	629		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,178,073	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,895		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(207)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,688	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,180,761	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 251,968	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,688,285		29
30	Accrued Salaries Payable	165,712		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,303		31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,663		32
33	Accrued Interest Payable	72,689		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	11,026		36
37	Accrued Rent	61,125		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,347,771	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,347,771	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,167,010)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,180,761	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,200,089)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,200,089)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	33,079	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 33,079	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,167,010)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,715,432	1
2	Discounts and Allowances for all Levels	(1,319,759)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,395,673	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,307,486	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,307,486	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,368	13
14	Non-Patient Meals	2,352	14
15	Telephone, Television and Radio	8,149	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 32,869	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	22,753	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,753	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	1,139	28
28a	Miscellaneous Other Income	477	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,616	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,760,397	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	729,338	31
32	Health Care	1,916,897	32
33	General Administration	614,195	33
B. Capital Expense			
34	Ownership	1,254,896	34
C. Ancillary Expense			
35	Special Cost Centers	157,789	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,727,318	40
41	Income before Income Taxes (line 30 minus line 40)**	33,079	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 33,079	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number Rosewood Care Center St Charles# 0041764Report Period Beginning: 07/01/2000Ending: 06/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,702	1,773	\$ 45,941	\$ 25.91	1
2	Assistant Director of Nursing	1,209	1,258	30,817	24.50	2
3	Registered Nurses	16,916	17,609	387,790	22.02	3
4	Licensed Practical Nurses	9,989	10,398	185,563	17.85	4
5	Nurse Aides & Orderlies	47,915	49,879	575,827	11.54	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,261	2,354	28,246	12.00	8
9	Activity Director					9
10	Activity Assistants	4,455	4,638	51,542	11.11	10
11	Social Service Workers	3,173	3,303	42,460	12.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,983	21,843	188,169	8.61	15
16	Dishwashers					16
17	Maintenance Workers	2,138	2,225	24,280	10.91	17
18	Housekeepers	15,591	16,230	126,831	7.81	18
19	Laundry	4,369	4,548	31,881	7.01	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,635	12,112	151,246	12.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,631	2,739	33,729	12.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,967	150,909	\$ 1,904,322 *	\$ 12.62	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	210	\$ 4,860	1-3	35
36	Medical Director	Contract	1,044	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	110	1,998	11-3	44
45	Social Service Consultant	145	2,600	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	465	\$ 10,502		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	5,188	88,197	10-3	51
52	Nurse Aides	2,152	19,370	10-3	52
53	TOTAL (lines 50 - 52)	7,340	\$ 107,567		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles

0041764

Report Period Beginning: 07/01/2000

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	Description	Amount		
R. Vanrhee	Administrator	0.00%	\$ 13,742	Workers' Compensation Insurance	\$ 56,466	IDPH License Fee	\$	Advertising: Employee Recruitment	17,577		
C. King	Adminstrator	0.00%	43,916	Unemployment Compensation Insurance		Health Care Worker Background Check (Indicate # of checks performed 70)		Misc. Dues/Subscriptions	687		
				FICA Taxes	143,214			Promotional Advertising	5,921		
				Employee Health Insurance	7,041			Management Company Allocations	657		
				Employee Meals							
				Illinois Municipal Retirement Fund (IMRF)*							
				Employee Physicals	361						
				Employee Uniforms	614						
				State Unemployment Tax	6,891						
				Federal Unemployment Tax	7,898						
				Employee Relations	2,294						
				Management Company Allocations	28,316						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center St Charles

STATE OF ILLINOIS

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,471 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES N/A NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,352
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. No facility specific audit report
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.